Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

G PETER FOOX MD
P O BOX 8795
TYLER TX 75711

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2234-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "NEED FEE SCHEDULE PAYMENT…NO RESPONSE…see attached…We resubmitted via fax 10/04/2011…They never acknowledged paid or denied, We called today and told they no longer handle this claim…I don't know who does but just needed to get it paid correctly the first time or at least get a timely re-sponse."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We only recently became the carrier. Another carrier issued this payment we are trying to get additional information in order to determine if additional reimbursement is needed. Will Amend Response to advise."

Response Submitted by: Liberty Mutual Insurance Co., P. O. Box 3423, Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2011	99456-W5-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 27, 2011
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - Charge exceeds Fee Schedule allowance

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR).
2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the narrative documentation submitted supports the rating of the right ankle/foot (lower extremity) with the Range of Motion (ROM) Impairment Rating method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the right ankle/foot is per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00. The combined Maximum Allowable Reimbursement (MAR) for the MMI/IR exam is $650.00.
3. The respondent has previously reimbursed the amount of $500.00 for the disputed MMI/IR. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 18, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.